Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

**Breast Imaging Kingston** site
820 John Marks Ave, KINGSTON, ON K7K 0J7
TEL: (613) 384-4284 FAX: (613) 544-2504

# BREAST IMAGING REQUISITION

Appointment Date/Time:_____

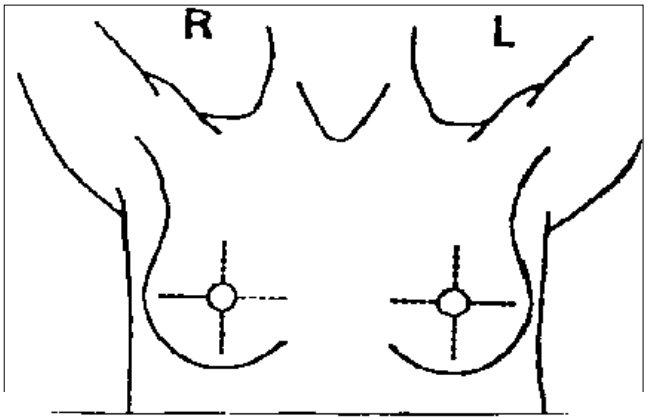
OBSPK#:_____

CR#:
Name:
Date of Birth
Address:

Postal Code:
Home Tel#:
Business Tel #:
HN #:
Family Physician:

| Right | Left | |
|---|---|---|
| ☐ | ☐ | **Routine screening mammogram** |
| ☐ | ☐ | **Diagnostic Mammogram** |
| ☐ | ☐ | |
| ☐ | ☐ | **Cone magnification** |
| ☐ | ☐ | **Ultrasound** |

**Please indicate location of abnormality below**




**RADIOLOGY CONSULT FOR:**

| | | |
|---|---|---|
| ☐ | ☐ | **Image Guided Core Biopsy** |
| ☐ | ☐ | **Fine needle aspiration** |
| ☐ | ☐ | **Mag Seed or Clip Placement** |
| ☐ | ☐ | **Sentinel Node Biopsy** |

**Previous Mammogram completed at:_____ Date:_____**

**Clinical Information and History:**

**Breast Implant?** ☐ **Right** ☐ **Left**

**Details of Current Findings:**

_____

_____

_____

_____

**I also agree that any of the following be arranged at the discretion of the Radiologist: core biopsy, fine needle aspiration or other breast imaging as required.**

**Signature: _____for_____**

**Physician name (print): _____**

**Date: _____**

**Send a copy of report to:**

_____

_____

_____